**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

NORTH AUSTIN SURGERY CENTER
12201 RENFERT WAY SUITE 120
AUSTIN TX 78758-5362

**Respondent Name**

NEW HAMPSHIRE INSURANCE CO

**Carrier's Austin Representative Box**

Box Number 19

**MFDR Tracking Number**

M4-12-1613-01

**MFDR Date Received**

JANUARY 17, 2012

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Overpayment 153% Medicare w/Implants. Implants allowed at 100% of Cost."

**Amount in Dispute:** $472.64

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The requestor alleges it is entitled to reimbursement in the amount of $6353.00 per the Table of Disputed Services (although correspondence from the requestor prior to the request for medical dispute resolution indicated a belief that the proper reimbursement amount should be $6573.6). The carrier has determined the correct reimbursement rate is $5880.36. This amount is consistent with the applicable fee guidelines, and consequently, no additional reimbursement is due."

**Response Submitted by:** Flahive, Ogden & Latson

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| July 8, 2011 | ASC Services for CPT Code 23552-RT | -$1491.95 | $0.01 |
| | ASC Services for CPT Code 23120-RT | -$499.74 | -$0.01 |
| | ASC Services for CPT Code 64415-59-RT | -$60.17 | $0.00 |
| | ASC Services for HCPCS Code C1713 | $897.60 | $0.00 |
| | ASC Services for HCPCS Code L8699 | $1,626.90 | $0.00 |
| TOTAL | | $472.64 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - W1-Workers compensation jurisdictional fee schedule adjustment.
   - Note: if adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2110 Service Payment Information REF), if present.
   - 97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - No reconsideration adjustment is necessary for this service/supply. Original recommendation is correct.
   - 59-Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia).

**Issues**

1. Does the documentation support that the requestor initially requested separate reimbursement for the implantables?
2. Does the documentation support that the implantables were certified? Is the requestor entitled to reimbursement for HCPCS codes C1713 and L8699?
3. Did the respondent make an overpayment for code 23552-RT?
4. Did the respondent make an overpayment for code 23120-RT?
5. Did the respondent make an overpayment for code 64415-59-RT?

**Findings**

1. 28 Texas Administrative Code §134.402(f)(1) states that reimbursement for non-device intensive procedures shall be "(A) The Medicare ASC facility reimbursement amount multiplied by 235 percent; or (B) if an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the non-device intensive procedure shall be the sum of: (i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission; and (ii) the Medicare ASC facility reimbursement amount multiplied by 153 percent."

   The requestor states in the August 18, 2011 appeal letter to the respondent that "We have received payment for the above referenced claim in the amount of $5880.36. Per the Texas Workers' Compensation billing guidelines, the reimbursement was made in error. Per the Texas Workers' Compensation billing guidelines, there are 2 options for the reimbursement of claims. 1) when implants are not billed separately, the procedures are to reimburse at 235% of the Medicare fee schedule, and 2) when implants are billed separately, the procedures are to reimburse at 153% of the Medicare fee schedule. As we did bill the implant separately, we were expecting reimbursement outlined in option 2."

   A review of the submitted August 18, 2011 bill finds that the requestor lists HCPCS code C1713 and L8699 on the bill; however, there is no clear request on the bill or attached documentation for separate reimbursement for the implants.

   The Division concludes that based upon the submitted documentation, the respondent appropriately made payment for the disputed services in accordance with 28 Texas Administrative Code §134.402(f)(1)(A).

2. 28 Texas Administrative Code §134.402 (g) states "A facility, or surgical implant provider with written agreement of the facility, may request separate reimbursement for an implantable. (1) The facility or surgical implant provider requesting reimbursement for the implantable shall: (B) include with the billing a certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge," and shall be signed by

an authorized representative of the facility or surgical implant provider who has personal knowledge of the cost of the implantable and any rebates or discounts to which the facility or surgical implant provider may be entitled."

A review of the submitted documentation and invoices finds that the requestor did not certify that the amount billed represents the actual cost for the implantables in accordance with 28 Texas Administrative Code §134.402 (g)(1)(B).

Based upon #1 and #2, the requestor is not entitled to separate reimbursement for HCPCS code C1713 and L8699. As a result, the amount recommended for reimbursement is $0.00.

3. 28 Texas Administrative Code §134.402(d) states " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

   CPT code 23552 is defined as "Open treatment of acromioclavicular dislocation, acute or chronic; with fascial graft (includes obtaining graft)."

   According to Addendum AA, CPT code 23552 is a non-device intensive procedure.

   Based upon the submitted documentation, the requestor did not certify or request separate reimbursement for the implantables; therefore the DWC conversion factor is 235%.

   The geographically adjusted Medicare ASC reimbursement for code 23552 is $1,819.47.

   To determine the MAR multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235%

   $1,819.47 X 235% = $4,275.75.

   The respondent paid $ 4,275.74. As a result, an overpayment was not made.

4. CPT code 23120 is defined as "Claviculectomy; partial."

   According to Addendum AA, CPT code 23120 is a non-device intensive procedure and is subject to multiple procedure discounting.

   The geographically adjusted Medicare ASC reimbursement for code 23120 is $1,218.87.

   To determine the MAR multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235%

   $1,218.87 X 235% = $2,864.34

   CPT code 23120 is subject to multiple procedure discounting; therefore, $2,864.34 X 50% = $1,432.17.

   The respondent paid $ 1,432.18. As a result, an overpayment of $0.01 was made.

5. CPT code 64415 is defined as "Injection, anesthetic agent; brachial plexus, single."

   The geographically adjusted Medicare ASC reimbursement for code 64415 is $146.76

   To determine the MAR multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235%

   $146.76 X 235% = $344.88

   CPT code 64415 is subject to multiple procedure discounting; therefore, $344.88 X 50% = $172.44.

   The respondent paid $ 172.44. As a result, payment was appropriately made.

**Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports additional reimbursement sought by the requestor. The Division concludes that the requestor did not support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

**Authorized Signature**

| | | |
|---|---|---|
| | | 06/05/2013 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.